MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00512 00515

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marcellus
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Long View Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upperco
d. STREET ADDRESS: Reisterstown Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alice — Middle: O. — Last: ARMACOST
4. DATE OF DEATH: Month: January — Day: 4 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: October 9, 1875
9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Upperco, Balto Co Maryland U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Martin
14. MOTHER'S MAIDEN NAME: Laura Cooper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 217-07-5185
17. INFORMANT: Mrs Wayson Armacost — Address: Upperco Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis
DUE TO (b): Arteriosclerotic Cardiovascular Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a.m. / p.m.; 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from May 1, 1963 to January 4, 1967 that (I) (we) last saw the deceased alive on January 3, 1967 and that death occurred at 8:37 PM, from the causes and on the date stated above.

22a. SIGNATURE: Joseph E. Bush M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-4-67
22c. PHYSICIAN'S NAME (Type): Joseph E. Bush M.D.
22d. ADDRESS: Hampstead Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/7/67
23c. NAME OF CEMETERY OR CREMATORY: St. Paul's Cemetery
23d. LOCATION (City, town or county) (State): Arcadia, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Tipton - Eline Funeral Home
ADDRESS: Hampstead, Md.
25a. REC'D BY REGISTRAR: DATE JAN 9 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00513 00516

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 4mos.25dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1729 Pulaski St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle NEWTON Last BARNETT

4. DATE OF DEATH: Month JANUARY Day 5 Year 19 67

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-4-1899
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Switchman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jasper Barnett
14. MOTHER'S MAIDEN NAME: Fannie Setzer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 216-09-4780
17. INFORMANT Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease with failure — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 8-10-66, 19__ to 1-5-67, 19__, that (I) (we) last saw the deceased alive on 1-5-67 19__, and that death occurred at 1:15 P.M. from causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo, M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 1-5-67
22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.
22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/9/67
23c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
23d. LOCATION (City or Town) (County) (State): A A Co. Md.

24. FUNERAL DIRECTOR: Arlington & Phillips ADDRESS: 1727 N. Monroe St.
25a. REC'D BY REGISTRAR DATE: JAN 6 1967
25b. REGISTRAR'S SIGNATURE: Charles Jaeger

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 (M)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00514 00517

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown 21741
d. STREET ADDRESS: Route #3
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Francis; Middle Brewer; Last BITTNER

4. DATE OF DEATH: Month January; Day 29; Year 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 7-12-1907

9. AGE (In years last birthday): 59 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Bittner - dec.

14. MOTHER'S MAIDEN NAME: Lillian Brewer - dec.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes (If yes give war or dates of service): 1941-1943

16. SOCIAL SECURITY NO.: 184-12-4007

17. INFORMANT: Springfield State Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction. — INTERVAL BETWEEN ONSET AND DEATH: minutes

4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary arteriosclerosis. — years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Schizophrenic reaction, paranoid type.

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: W. Glenn Speicher M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22. DATE SIGNED: 1-29-67

EXAMINER'S NAME (Type): W. Glenn Speicher, M.D.

Address (Street, city, town, or county): 33 E. Main Street Westminster Carroll Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/1/1967

23c. NAME OF CEMETERY OR CREMATORY: Leitersburg Lutheran

23d. LOCATION (City, town or county) (State): Leitersburg, Washington, Md.

24. FUNERAL DIRECTOR: Walter N. Grove — ADDRESS: Waynesboro, Penna.

25a. REC'D BY REGISTRAR DATE: FEB 2 1967

25b. REGISTRAR'S SIGNATURE: Charles Judy

VR A15ME
3500 4-64

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FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00515 00518

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH
   a. COUNTY: Carroll
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New Windsor
   c. LENGTH OF STAY IN 1b: minutes
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 110 Main St.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New Windsor
   d. STREET ADDRESS: 315 College Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gene Middle: Arthur Last: Bloom

4. DATE OF DEATH: Month: January Day: 24 Year: 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 4, 1928

9. AGE (In years last birthday): 38 yrs. IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fork lift operator

10b. KIND OF BUSINESS OR INDUSTRY: Congoleum Mfg.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: William Preston Bloom, Sr.

14. MOTHER'S MAIDEN NAME: Anna Jenkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes 12Jan1951-1956

16. SOCIAL SECURITY NO.: 216-22-7784

17. INFORMANT: Address: Mrs. Reita G. Bloom, New Windsor, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Shotgun Wound Lower Left Chest Anterior — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

976X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18): Apparently Shot Self with Shotgun

20c. TIME OF INJURY Month, Day, Year: Hour a.m. 5:00 p.m. 1-24 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): 110 Main St

20f. (City or town): New Windsor (County): Carroll (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W. Glenn Speicher M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): W. Glenn Speicher

Address (Street, city, town, or county): 12 E. Main St. Westminster, Carroll Md.

22. DATE SIGNED: 1-27-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan.27,1967

23c. NAME OF CEMETERY OR CREMATORY: Balto. National

23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR: ADDRESS: D. D. Hartzler & Sons, New Windsor, Md.

25a. REC'D BY REGISTRAR DATE: JAN 26 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME
3500 4-64

1 (M)

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00516

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00519

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster R.# 5
c. LENGTH OF STAY IN 1b: years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Jasontown Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster R. # 5 06-1
d. STREET ADDRESS: Jasontown Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): Fredrick — Middle: FREDERICK WILLIAM — Last: BOONE, SR.
4. DATE OF DEATH: Month: January — Day: 30, — Year: 1967
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 28, 1884
9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter-retired
10b. KIND OF BUSINESS OR INDUSTRY: Self employed
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?: U. S.
13. FATHER'S NAME: John Boone
14. MOTHER'S MAIDEN NAME: Justina Gries
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no — (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 219-32-2342
17. INFORMANT: Daniel E. Boone, Address: Westminster, Md. R.# 5

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shotgun wound of L Side Skull — INTERVAL BETWEEN ONSET AND DEATH: Instant.
976X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Shot Self in Head with Shotgun
20c. TIME OF INJURY Month, Day, Year: Hour 10-11 a.m. p.m. 1-30 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) R.D.5 Westminster (County) Carroll (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W. Glenn Speicher M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 1-30-67
EXAMINER'S NAME (Type): W. Glenn Speicher
Address (Street, city, town, or county): 135 E. Main St. Westminster Carroll Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb. 2, 1967
23c. NAME OF CEMETERY OR CREMATORY: St. Johns Cemetery
23d. LOCATION (City, town or county): Howard County, Md.

24. FUNERAL DIRECTOR: D.D. Hartzler & Sons — ADDRESS: New Windsor, Md.
25a. REC'D BY REGISTRAR — DATE: FEB 3 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00517

CERTIFICATE OF DEATH

00520

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr.8mos.29dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 9906 Markham Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JULIA — Middle BENSON — Last BRADBURN
4. DATE OF DEATH: Month JANUARY — Day 11 — Year 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5-28-1883
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benson Townshend
14. MOTHER'S MAIDEN NAME: Susanna Naylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor or dates of service)
16. SOCIAL SECURITY NO: Unk.
17. INFORMANT — Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute left Ventricular myocardial infarction
DUE TO: Coronary Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c): Bilateral Bronchopneumonia
INTERVAL BETWEEN ONSET AND DEATH: hours / years / day

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome assoc. with cerebral arteriosclerosis, with psychotic reaction
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-12-65, 19__ to 1-11-67, 19__, that (I) (we) last saw the deceased alive on 1-11-67 19__, and that death occurred at 2:50 PM from causes and on the date stated above.

22a. SIGNATURE: Dr. Antonius Glahn — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 1-11-67
22c. PHYSICIAN'S NAME (Type): Antonius Glahn, M. D.
22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: 14 Jan 67
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City or Town) (County) (State): Wash D. C.

24. FUNERAL DIRECTOR: S H Hines Co — ADDRESS: 2901-14th St Wash DC
25a. REC'D BY REGISTRAR — DATE: JAN 13 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00518

CERTIFICATE OF DEATH

00521

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster, Md.
c. LENGTH OF STAY IN 1b: 3 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Co. General Hospt. Westminster

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hampstead Rd. 1 — Md.
d. STREET ADDRESS: Rd. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: H. — Last: Brooks
4. DATE OF DEATH: Month: Jan. — Day: 10, — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 4, 1884
9. AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Hardware store
11. BIRTHPLACE (County & State or foreign country): Carroll Co. Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas D.. Brooks
14. MOTHER'S MAIDEN NAME: Zena Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 218-24-7515
17. INFORMANT — Address: Mrs. Harrison Brooks Hampstead, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 177X
DUE TO (b): Carcinoma of the Prostate
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pneumonia
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 21, 1966, to Jan 10, 1967 that (I) (we) last saw the deceased alive on Jan 10, 1967, and that death occurred at 3 A M, from causes and on the date stated above.

22a. SIGNATURE: John S. Harshey M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/10/67
22c. PHYSICIAN'S NAME (Type): JOHN S. HARSHEY M.D.
22d. ADDRESS: 8 anchor St. Westminster Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Jan. 12, 1967
23c. NAME OF CEMETERY OR CREMATORY: Snydersburg Cemetery
23d. LOCATION (City or Town) (County) (State): Hampstead, Carroll Md.

24. FUNERAL DIRECTOR — ADDRESS: Tipton - Eline Funeral Home Hampstead, Md.
25a. REC'D BY REGISTRAR DATE: JAN 12 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00519

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00522

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll County General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Sykesville
d. STREET ADDRESS: Route 2 Box 175
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MINNIE Middle E. Last BUSSARD

4. DATE OF DEATH: Month 1 — Day 8 — Year 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 27, 1897

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Andrew J. Ford

14. MOTHER'S MAIDEN NAME: Gertrude Summers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Laura L. Shipley — Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemmorrhage (Ruptured) — INTERVAL BETWEEN ONSET AND DEATH: Several
DUE TO (b): Arteriosclerotic Aortic Aneurism
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Arteriosclerosis & Hypertension — Several yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fractured Neck Left Femur

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Fell in Livingroom at Home

20c. TIME OF INJURY Month, Day, Year: Hour ~~a.m.~~ 7:00 p.m. 12-21 1966

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W. Glenn Speicher M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 1-8-67

EXAMINER'S NAME (Type): W. Glenn Speicher
Address (Street, city, town or county): 135 E. Main Street Westminster Carroll (State)

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/11/1967
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City, town or county) (State): Frederick, Maryland

24. FUNERAL DIRECTOR: C. L. Waltz
ADDRESS: Box 241 Sykesville, Md.

25a. REC'D BY REGISTRAR — DATE: JAN 10 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00520

CERTIFICATE OF DEATH

00523

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 4000 Park Heights Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ISRAEL — Middle: (NMN) — Last: CAPLAN

4. DATE OF DEATH: Month: JANUARY — Day: 18 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

8. DATE OF BIRTH: 5-4-1895

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor

10b. KIND OF BUSINESS OR INDUSTRY: Shop

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Isaac D. Caplan

14. MOTHER'S MAIDEN NAME: Sarah Pollack

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 218-52-1357

17. INFORMANT Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Hours
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-17-67, 19__ to 1-18-67, 19__, that (I) (we) last saw the deceased alive on 1-18-67 19__, and that death occurred at 10:20 P.M. from causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo. — M.D — ATTENDING PHYS. ☐ — MED. DIRECTOR ☐ — STAFF PHYS. ☒
22b. DATE SIGNED: 1-19-67
22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M. D.
22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/20/67
23c. NAME OF CEMETERY OR CREMATORY: Sfard Ohr Knesseth Israel Anshe
23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR ADDRESS: Sol Levinson & Bros. Inc., 6010 Reist., Rd.

25a. REC'D BY REGISTRAR DATE: JAN 23 1967
25b. REGISTRAR'S SIGNATURE: Charles Young

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00521

CERTIFICATE OF DEATH

00524

1. PLACE OF DEATH — a. COUNTY: Carroll , Sykesville — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
   c. LENGTH OF STAY IN 1b: 25y. 5m. 18d.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: Maryland, — b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Germantown, Md.
   d. STREET ADDRESS
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Russell — Middle: Knight — Last: Crutchley

4. DATE OF DEATH: Month: January — Day: 23, — Year: 1967

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 2-2-1899

9. AGE (In years last birthday): 67 yrs
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (County & State, or foreign country): Montgomery, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William E. Crutchley

14. MOTHER'S MAIDEN NAME: Lydia Harley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-54-6297

17. INFORMANT — Address: Springfield Hospital Records, Sykesville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Cor pulmonale
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Kyphoscoliosis
434.0

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-6, 1941, to 1-23, 1967, that (I) (we) last saw the deceased alive on 1-23 1967, and that death occurred at 9:15 M, from causes and on the date stated above.

22a. SIGNATURE: Glocrito G. Sagisi — M.D — ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 1-24-67

22c. PHYSICIAN'S NAME (Type): Glocrito G. Sagisi

22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1-26-67

23c. NAME OF CEMETERY OR CREMATORY: Clarksburg Methodist

23d. LOCATION (City or Town) (County) (State): Clarksburg, Md.

24. FUNERAL DIRECTOR — ADDRESS: Francis H. Barber Laytonsville, Md.

25a. REC'D BY REGISTRAR — DATE: JAN 27 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00522

CERTIFICATE OF DEATH

00525

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Manchester Md
c. LENGTH OF STAY IN 1b: 2 wks
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Longview Nursing Home.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Carroll
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hutton
d. STREET ADDRESS: No street address
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Bertha — Middle: Missouri — Last: Dorsey

4. DATE OF DEATH: Month: 1 — Day: 10 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Jan 31, 1882

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS. — Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): New Emmetsburg Md Frederick

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John David Keilholtz

14. MOTHER'S MAIDEN NAME: Anna Missouri Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 216-14-5628D

17. INFORMANT: Son Charles W. Dorsey — Address: 72 Church St Westminster Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis — 5 yrs
DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 28, 1966, to Jan 10, 1967, that (I) (we) last saw the deceased alive on Jan 9 1967, and that death occurred at 12:00 PM, from the causes and on the date stated above.

22a. SIGNATURE: W H Foard — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/10/67

22c. PHYSICIAN'S NAME (Type): W. H Foard

22d. ADDRESS: Manchester, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1-13-67

23c. NAME OF CEMETERY OR CREMATORY: Mt. Tabor Cemetery

23d. LOCATION (City, town or county) (State): Rocky Ridge Fred. Co. Md.

24. FUNERAL DIRECTOR: Raymond E. Creager — ADDRESS: Thurmont, Md.
Raymond E. Creager

25a. REC'D BY REGISTRAR: JAN 16 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00523

CERTIFICATE OF DEATH

00526

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit (if any), please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: CARROLL CO. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER RT#7
c. LENGTH OF STAY IN 1b: 3 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HUGHES SHOP ROAD

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER, RT#7
d. STREET ADDRESS: HUGHES SHOP ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KENNETH Middle LESLIE Last EMERY

4. DATE OF DEATH: Month JAN. Day 13 Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 14, 1914

9. AGE (In years last birthday): 52 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALES MANAGER

10b. KIND OF BUSINESS OR INDUSTRY: FARM MACHINERY

11. BIRTHPLACE (County & State, or foreign country): HARLANSBURG, PA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES N. EMERY

14. MOTHER'S MAIDEN NAME: MARY V. EAKIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) ___ (If yes give war or dates of service) ___

16. SOCIAL SECURITY NO: 167-03-2601

17. INFORMANT: MRS KENNETH L. EMERY, Address SAME ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cardiac arrest
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c): ___
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4/21.1
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ___, 1964, to Jan 13, 1967, that (I) (we) last saw the deceased alive on Jan 11, 1967, and that death occurred at 9:4 M, from causes and on the date stated above.

22a. SIGNATURE: John S. Harshey M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/13/67

22c. PHYSICIAN'S NAME (Type): JOHN S. HARSHEY, M.D.

22d. ADDRESS: 8 Anchor St. Westminster, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1/17/67

23c. NAME OF CEMETERY OR CREMATORY: HARLANSBURG CEMETERY

23d. LOCATION (City or Town) (County) (State): HARLANSBURG Pa.

24. FUNERAL DIRECTOR: J. S. Snyder Jr. ADDRESS: WESTMINSTER, MD

25a. REC'D BY REGISTRAR DATE: JAN 16 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00524

CERTIFICATE OF DEATH

00527

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: CARROLL CO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 19 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CARROLL CO. GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER, RT. #7
d. STREET ADDRESS: HUGHES SHOP ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First MARY Middle VIOLA Last EMERY

4. DATE OF DEATH: Month 1 Day 13 Year 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 26 1878

9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE-WIFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): HARLANSBURG, PA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM EAKIN

14. MOTHER'S MAIDEN NAME: ELIZABETH NELSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes give war or dates of service)

16. SOCIAL SECURITY NO: 213-48-3829

17. INFORMANT: MRS. KENNETH L. EMERY — Address: WESTMINSTER, RT#7 MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CEREBRAL ISCHEMIA — INTERVAL BETWEEN ONSET AND DEATH: IMMED.
DUE TO
(b): CEREBRAL ARTERIOSCLEROSIS — YEARS
DUE TO
(c): —
3 3 Y A
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ARTERIOSCLEROTIC HEART DISEASE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 6, 1966, to 1/13, 1967, that (I) (we) last saw the deceased alive on 1/12 1967, and that death occurred at 4:35 M, from causes and on the date stated above.

22a. SIGNATURE: Vincent J. Flores Jr. M.D. — ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 1/13/67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1/17/67

23c. NAME OF CEMETERY OR CREMATORY: HARLANSBURG CEMETERY

23d. LOCATION (City or Town) (County) (State): HARLANSBURG, Pa.

24. FUNERAL DIRECTOR — ADDRESS: J. E. Myers Jr., Westminster

25a. REC'D BY REGISTRAR DATE: JAN 16 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00525

CERTIFICATE OF DEATH

00528

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 18 Months
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pullen Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woodbine
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: E. — Last: Fleming

4. DATE OF DEATH: Month: January — Day: 26, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 6, 1882

9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter - Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Carroll Co., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William P. Fleming

14. MOTHER'S MAIDEN NAME: Susan Mullinix

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
   (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Mr. Roy Fleming Milwaukee, Wis.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Arteriosclerosis, generilzed; A.S.H.D.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b): Cardiac failure, bronchial pneumonia.

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 1964 Jan.26,67

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1964, 19, to Jan. 26, 19 67 that (I) (we) last saw the deceased alive on Jan. 26, 19 67, and that death occurred at 4:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Howard E Hall M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Jan. 27, 1967

22c. PHYSICIAN'S NAME (Type): Howard E. Hall, M.D.

22d. ADDRESS: Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/29/1967

23c. NAME OF CEMETERY OR CREMATORY: Lorsen Chapel Cemetery

23d. LOCATION (City, town or county) (State): Carroll Co., Md.

24. FUNERAL DIRECTOR'S SIGNATURE: S. M. Waltz

ADDRESS: Box 241 Sykesville, Md.

25a. REC'D BY REGISTRAR DATE: JAN 31 1967

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

VR A1S (4) 20M S-63

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00526 . **CERTIFICATE OF DEATH** 00529

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 17 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Co. General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Reisterstown 21136
d. STREET ADDRESS: Box 17 Berrymans Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First WALTER Middle Last FRANKLIN

4. DATE OF DEATH: Month 1 Day 31 Year 1967

5. SEX: M. — 6. COLOR OR RACE: W — 7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: Feb. 5 1892 — 9. AGE (In years last birthday): 74 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ornamental Worker — 10b. KIND OF BUSINESS OR INDUSTRY: Iron Bus — 11. BIRTHPLACE (County & State, or foreign country): Balto. — 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Benjamin P. Franklin — 14. MOTHER'S MAIDEN NAME: Emelain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 215-10-0895A

17. INFORMANT: Mrs. Elma S. Franklin — Address: Box 17 Berrymans Lane 21136

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC ARREST — INTERVAL BETWEEN ONSET AND DEATH: IMMED
4201
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): CORONARY INSUFFICIENCY — MOS
DUE TO
(c): ARTERIOSCLEROTIC HEART DISEASE — YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CEREBRAL VASCULAR INSUFFICIENCY

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/4, 1967, to 1/31, 1967, that (I) (we) last saw the deceased alive on 1/31 1967, and that death occurred at 5:55 P M, from causes and on the date stated above.

22a. SIGNATURE: Vincent J. Rocco Jr. M.D. — ATTENDING PHYS ☑ MED. DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: 1/31/67
22c. PHYSICIAN'S NAME (Type): Vincent J. Rocco — 22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): — 23b. DATE THEREOF: 2-4-1967 — 23c. NAME OF CEMETERY OR CREMATORY: Dyvid Ridge — 23d. LOCATION (City or Town) (County) (State): Pikesville 21208 Md

24. FUNERAL DIRECTOR: Young Byers — ADDRESS: 8728 Liberty Rd Randallstown, 21133 — 25a. REC'D BY REGISTRAR DATE: FEB 2 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00527

CERTIFICATE OF DEATH

00530

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FINKSBURG
c. LENGTH OF STAY IN 1b: 10 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): OLD BALTIMORE RD.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FINKSBURG
d. STREET ADDRESS: OLD BALTIMORE RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH — Middle MAURICE — Last FRAZIER

4. DATE OF DEATH: Month JAN. — Day 10 — Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: OCT. 15 1886

9. AGE (In years last birthday): 80 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MACHINIST, NAVAL GUN FACTORY

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): FINKSBURG CARROLL Co. MD U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: GEORGE H. FRAZIER

14. MOTHER'S MAIDEN NAME: MARY LAUER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES — (If yes give war or dates of service): WWI

16. SOCIAL SECURITY NO.: —

17. INFORMANT: JOS. M. FRAZIER JR. — Address: FINKSBURG, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: ½ hr.

4-20-1

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic C.V. Disease with — years
DUE TO (c): cardiac decompensation

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 2, 1960 to Jan. 10, 1967, that (I) (we) last saw the deceased alive on Jan. 10 1967, and that death occurred at 5:15 P.M. From the causes and on the date stated above.

22a. SIGNATURE: Martin E. Strobel — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 1-11-67

22c. PHYSICIAN'S NAME (Type): Martin E. Strobel, M.D.

22d. ADDRESS: 48 Main St. Reisterstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1/13/67

23c. NAME OF CEMETERY OR CREMATORY: FINKSBURG CEMETERY

23d. LOCATION (City, town or county) (State): FINKSBURG, MD

24. FUNERAL DIRECTOR — ADDRESS: J. E. Myers Jr., WESTMINSTER MD

25a. REC'D BY REGISTRAR — DATE: JAN 13 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00528 00531

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville, Md.
c. LENGTH OF STAY IN 1b: 4 Mon.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pullen Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester, Md.
d. STREET ADDRESS: 11 Westminster St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lizzie (Liggie) Middle: N. Last: Haines

4. DATE OF DEATH: Month: 1 Day: 10 Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 26, 1883

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sewing Machine Opp.

10b. KIND OF BUSINESS OR INDUSTRY: Clothing Factory

11. BIRTHPLACE (County & State, or foreign country): Carroll Co. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William H. Newcomer

14. MOTHER'S MAIDEN NAME: Amanda Shaffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 218-03-6678

17. INFORMANT: Miss Alice Haines Address: Manchester, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Hemiplegia — 10 yrs.
DUE TO (c): A.C.V.D — 10 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus, Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. [Enter nature of injury in Part I or Part II of item 18.]

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 12-12, 19 66 to Jan 10, 19 67, that (I) (~~we~~) last saw the deceased alive on 12-12-1966, and that death occurred at 8:14 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Sam Okutman M.D.

22c. PHYSICIAN'S NAME (Type): Sam Okutman

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1.10.67

22d. ADDRESS: Sykesville, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 13, 1967

23c. NAME OF CEMETERY OR CREMATORY: Lineboro Cemetery

23d. LOCATION (City, town or county) (State): Lineboro, Md.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Tipton - Eline Funeral Home Hampstead, Md.

25a. REC'D BY REGISTRAR DATE: JAN 12 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
2M M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00529 00532

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 48 Market Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Howell — Middle: Henry — Last: Haynes

4. DATE OF DEATH: Month: January — Day: 22 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 12-11-36

9. AGE (In years last birthday): 30 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter Haynes

14. MOTHER'S MAIDEN NAME: Bridgett (illegible) Faulkner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes Army RA13504477

16. SOCIAL SECURITY NO.: 228-50-5367

17. INFORMANT: Springfield Hospital Records — Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Miliary tuberculosis, active
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: Weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
CBS, of unknown or uncertain cause with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter Nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 17, 1967 to Jan. 22, 1967, that (I) (we) last saw the deceased alive on Jan. 22 19 67, and that death occurred at 8:30 AM, from causes and on the date stated above.

22a. SIGNATURE: Julian Radzykewycz M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1-22-67

22c. PHYSICIAN'S NAME (Type): JUlian Radzykewycz, M.D.

22d. ADDRESS: Springfield State Hosp. Sykesville, Maryland

23a. BURIAL CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: 1-26-1967

23c. NAME OF CEMETERY OR CREMATORY: East Hill Cemetery

23d LOCATION (City or Town) (County) (State): Bristol, Virginia

24 FUNERAL DIRECTOR ADDRESS: Howard H. Hubbard, 4107 Wilkens Ave. 21229

25a REC'D BY REGISTRAR DATE: JAN 26 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 23b,23c,23d Film G384 1/17/67 mh

CERTIFICATE OF DEATH

00530 Item 2 Film G383 1/4/67 mh 00533

1 PLACE OF DEATH

a. COUNTY: Carroll — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Sykesville

c. LENGTH OF STAY IN 1b: Oy 3m 21d

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE: Maryland — b. COUNTY: Frederick Co.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Montevue County Home~~ Knoxville

d. STREET ADDRESS: ~~Frederick~~, Maryland

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
Jesse	James	Himes	1	12	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white		12-25-1896	70 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	-	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel Himes	Anna Pierce

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
yes 1918	None	Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Acute Posterior Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO (b): Arteriosclerotic heart disease — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1/20.1

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome, cerebral arteriosclerosis with behavioral reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): --

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
-- -- 19		--	--		

21. I **certify** that ~~I~~ (this hospital) attended the deceased from 9-21, 1966, to 1-12, 1967, that ~~I~~ (we) last saw the deceased alive on 1-12 1967, and that death occurred at 6:12 M, from causes and on the date stated above.

22a. SIGNATURE	M.D	ATTENDING PHYS ☐	MED. DIRECTOR ☐	STAFF PHYS. ☒	22b. DATE SIGNED
Heinz H. Klaatsch, M.D.					1-12-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Heinz H. Klaatsch	Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	1-14-67	Arlington National	Fort Myer, Va.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Elva Feete	Brunswick Md	JAN 17 1967	J. Charles Judge

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00531 00534

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 50 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CARROLL CO. GEN. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
d. STREET ADDRESS: 19 LOCUST AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARENCE — Middle AUGUSTUS — Last HUMBERT

4. DATE OF DEATH: Month JAN — Day 6 — Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 18, 1892

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER - JANITOR, PRINTING CO.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): SILVER RUN, CARROLL, MD U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: AUGUSTUS G. HUMBERT

14. MOTHER'S MAIDEN NAME: ADA DELL

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unknown): —
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 220-16-1841

17. INFORMANT: MRS. LAURA J. HUMBERT, Address SAME ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 420.0
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: many years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 6, 19 67, to Jan 6, 19 67, that (I) (we) last saw the deceased alive on DOA 19, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: John S. Harshey M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/6/67

22c. PHYSICIAN'S NAME (Type): JOHN C. HARSHEY, M.D.

22d. ADDRESS: 8 Church St. Westminster Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1/9/67

23c. NAME OF CEMETERY OR CREMATORY: EVERGREEN MEM. GARDENS

23d. LOCATION (City, town or county) (State): FINKSBURG RD #1 MD

24. FUNERAL DIRECTOR: J. E. Myers — ADDRESS: WESTMINSTER MD.

25a. REC'D BY REGISTRAR DATE: JAN 9 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00532

CERTIFICATE OF DEATH

00535

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNIONTOWN
c. LENGTH OF STAY IN 1b: 15 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): JASONTOWN ROAD

2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNIONTOWN
d. STREET ADDRESS: JASONTOWN ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ALVIN — Middle WHITNEY — Last HUTCHINSON

4. DATE OF DEATH: Month JAN. — Day 7 — Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEB. 22 1903

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: SELF-EMPLOYED

11. BIRTHPLACE (County & State, or foreign country): BALTIMORE, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LEWIS NOAH HUTCHINSON

14. MOTHER'S MAIDEN NAME: EMMA L. HAMMOND

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 212-40-4517

17. INFORMANT: MRS. ALVIN W. HUTCHINSON — Address (SAME)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c): (Lt. mandible - original site)

INTERVAL BETWEEN ONSET AND DEATH: 6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 1, 1966 to 11/6/67, 19___, that (I) ~~(we)~~ last saw the deceased alive on 11/6/67 19___, and that death occurred at 4:35 P.M. from causes and on the date stated above.

22a. SIGNATURE: M. E. Robertson — M.D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/7/67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: New Windsor, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1/10/67

23c. NAME OF CEMETERY ~~OR CREMATORY~~: PLEASANT VALLEY

23d. LOCATION (City or Town) (County) (State): PLEASANT VALLEY, MD.

24 FUNERAL DIRECTOR — ADDRESS: J. E. Myers, Jr., Westminster, Md.

25a. REC'D BY REGISTRAR DATE JAN 9 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00533

CERTIFICATE OF DEATH

00536

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll County General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Abingdon
d. STREET ADDRESS: 612 W. Baker Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: GEORGE — Middle: WEBSTER — Last: JOHNSON
4. DATE OF DEATH: Month: 1 — Day: 30 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: Cau.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 17, 1904
9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Manager
10b. KIND OF BUSINESS OR INDUSTRY: Store
11. BIRTHPLACE (County & State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Oscar M. Johnson
14. MOTHER'S MAIDEN NAME: Mary Alice Palmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): None (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 123-09-0777
17. INFORMANT — Address: Wife, Same as 2 C & D above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY — INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a): CARCINOMATOSIS — MONTHS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): CARCINOMA OF ASCENDING
~~DUE TO~~
(c): COLON — YEARS

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/20, 1967 to 1/30, 1967, that (I) (we) last saw the deceased alive on 1/30 1967, and that death occurred at 1:35 M, from causes and on the date stated above.

22a. SIGNATURE: Vincent J. Fiocco Jr. M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 1/30/67
22c. PHYSICIAN'S NAME (Type): Vincent J. Fiocco, Jr. M.D. — 22d. ADDRESS: Westminister, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1 Feb. 67
23c. NAME OF CEMETERY OR CREMATORY: Spesutia Cemetery
23d. LOCATION (City or Town) (County) (State): Perryman, Maryland

24. FUNERAL DIRECTOR: Webster Tarring Sr. — ADDRESS: Tarring Funeral Home Aberdeen, Md.
25a. REC'D BY REGISTRAR DATE: FEB 1 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 10 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G384 1/66/67 pc

00534

CERTIFICATE OF DEATH

00537

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Maryland — b. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville — c. LENGTH OF STAY IN 1b: 10mos.12dys.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital	d. STREET ADDRESS: 331 N. Ohio Street — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
JULIA	ORA	JOHNSON	JANUARY	5	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min
Female	Negro		4-27-1899	66/67 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Virginia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
(First name unk.) White	Hattie Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	218-05-2544-T	Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years

DUE TO

(b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO

(c): Chronic fibrous pulmonary tuberculosis — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome assoc. with cerebral arteriosclerosis, with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-23-66, 19__ to 1-5-67, 19__, that (I) (we) last saw the deceased alive on 1-5-67 19__, and that death occurred at 11:50 PM, from causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS ☒	22b. DATE SIGNED
Agustin del Campo.		1-6-67
22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M. D.	22d. ADDRESS: Springfield State Hospital Sykesville, Maryland	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	1-11-67	Baltimore National	Baltimore Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Elmer T. Bullock Havre de Grace, Md.	JAN 11 1967	Edward Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00535 — 00538

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Sykesville
c. LENGTH OF STAY IN 1b: No Time
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 26

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Finksburg
d. STREET ADDRESS: Gamber
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Patricia — Middle: Ann — Last: Johnson

4. DATE OF DEATH: Month: Jan. — Day: 1 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-13-49

9. AGE (In years last birthday): 17 yrs.
IF UNDER 1 YEAR — Months: — Days:
IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: School

11. BIRTHPLACE (State or foreign country): West Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles L. Johnson

14. MOTHER'S MAIDEN NAME: Dorothy L. Hayes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): --

16. SOCIAL SECURITY NO.: 216-52-8862

17. INFORMANT — Address: Mr. Charles Johnson Rt. 2 Finksburg

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Laceration Scalp
DUE TO (b): Fractured Skull & Neck
DUE TO (c): Contusion Chest & Laceration Liver
Multiple Fractures both Legs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Few Minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Head on Collision with Truck

20c. TIME OF INJURY Month, Day, Year: Hour 12:24 a.m. p.m. — 1-1 — 19 67

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 26

20f. (City or town) R.D. Sykesville (County) Carroll (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W. Glenn Speicher M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 1-1-67

EXAMINER'S NAME (Type): W. Glenn Speicher

Address (Street, city, town, or county): 1366 Main St. Westminster Carroll (State)

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1-5-67

23c. NAME OF CEMETERY OR CREMATORY: Mt. View

23d. LOCATION (City, town or county) (State): Howard Co. Md.

24. FUNERAL DIRECTOR: Harry W. Haight — ADDRESS: Sykesville, Md.

25a. REC'D BY REGISTRAR — DATE: JAN 10 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME
35DD 4-64

1 (M)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in report to Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00536 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 00539

1. PLACE OF DEATH
a. COUNTY Carroll / Baltimore — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 429 Rt. # 3

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville Md.
d. STREET ADDRESS Box 429 Rt. #3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Mark Middle: James Last: Keitz
4. DATE OF DEATH Month: Jan. Day: 3. Year: 1967

5. SEX: M
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/16/1962
9. AGE (In years last birthday): 4 yrs. IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ernest Harris Keitz Jr.
14. MOTHER'S MAIDEN NAME: Carol Lee Birchall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. Ernest H. Keitz Jr.-Box 429 Rt. # 3 Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Compound Fracture Skull 812.4
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Fracture of Rt Arm & Shoulder
DUE TO (c) Struck by car When Pedestrian on Highway
INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Pedestrian on driveway on White Rock Road Struck by automobile driven
20c. TIME OF INJURY Month, Day, Year: Hour 4:30 a.m. p.m. 1-3 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): White Rock Rd
20f. (City or town) Sykesville (County) Carroll (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Sylvia Spencer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): 1337 Hanover Pike Westminster Carroll Co. Md.
22. DATE SIGNED: 1-3-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/5/67
23c. NAME OF CEMETERY OR CREMATORY: Lakeview Cemetery
23d. LOCATION (City, town or county) (State): Liberty Rd Baltimore Carroll Co. Md.

24. FUNERAL DIRECTOR ADDRESS: Loring Byers-8728 Liberty Rd. Randallstown, Md.
25a. REC'D BY REGISTRAR DATE: JAN 6 1967
25b. REGISTRAR'S SIGNATURE

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00537

CERTIFICATE OF DEATH

00540

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Sykesville
c. LENGTH OF STAY IN 1b: OY OM 23D
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown 21741
d. STREET ADDRESS: 125 N. Prospect Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

12

3 NAME OF DECEASED (Type or print): First: Frank — Middle: (NMN) — Last: Keyser

4 DATE OF DEATH: Month: 1 — Day: 16 — Year: 19 67

5. SEX: male

6. COLOR OR RACE: white

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: ?-?-1884

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (County & State, or foreign country): Washington County

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel E. Keyser

14. MOTHER'S MAIDEN NAME: Mary Ellen Carl

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)

16 SOCIAL SECURITY NO.: None

17 INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO
(b): Generalized arteriosclerosis — years
DUE TO
(c):

420.1

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

2

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with senile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ---

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. --- 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State): ---

21. I certify that I (this hospital) attended the deceased from 12-23- , 1966 to 1-16 , 1967, that I (we) last saw the deceased alive on 1-16- 19 67, and that death occurred at 8:45 P.M. from causes and on the date stated above.

22a. SIGNATURE: José Palacio M.D.
M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 1-17-67

22c. PHYSICIAN'S NAME (Type): José Palacio, M.D.
22d. ADDRESS: Springfield State Hospital

1

14

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/19/67
23c. NAME OF CEMETERY OR CREMATORY: Broadfording Cemetery
23d. LOCATION (City or Town) (County) (State): Broadfording Washington Md.

24. FUNERAL DIRECTOR: Rest Haven Funeral Chapel, Inc.
ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: JAN 19 1967
25b. REGISTRAR'S SIGNATURE: Florence Young

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00538

CERTIFICATE OF DEATH

00541

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2yrs.5mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brunswick
d. STREET ADDRESS: 109 5th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EDWARD — Middle: RAYMOND — Last: McINTOSH
4. DATE OF DEATH: Month: JANUARY — Day: 31 — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-12-10
9. AGE (In years last birthday): 56 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Conductor
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Homer C. McIntosh
14. MOTHER'S MAIDEN NAME: Zula Shepler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO: UNKNOWN
17. INFORMANT — Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Infarction of brain stem — INTERVAL BETWEEN ONSET AND DEATH: Days
DUE TO (b): Embolism in posterior cerebellar artery — Days
DUE TO (c): Multiple recent infarcts in the right & left ventricular muscle due to cerebral arteriosclerosis — Days & Years
332X
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CBS with circulatory disturbance other than cerebral arteriosclerosis, cerebral hemorrhage, with behavioral reaction
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-31-64, 19__, to 1-31-67, 19__, that (I) (we) last saw the deceased alive on 1-31-67, 19__, and that death occurred at 8:55 A.M. from causes and on the date stated above.

22a. SIGNATURE: Octavio A Ruiz — M.D. — ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 2-1-67
22c. PHYSICIAN'S NAME (Type): Octavio A. Ruiz, M. D.
22d. ADDRESS: Springfield State Hospital, Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 2/4/67
23c. NAME OF CEMETERY OR CREMATORY: Resthaven Memorial Gardens
23d. LOCATION (City or Town) (County) (State): Frederick Fred. Md

24. FUNERAL DIRECTOR: Elmer Feete — ADDRESS: Brunswick Md
25a. RECD BY REGISTRAR — DATE: FEB 3 1967
25b. REGISTRAR'S SIGNATURE: Charles Yingling

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00539 — 00542

1. PLACE OF DEATH
a. COUNTY: CARROLL CO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SYKESVILLE
c. LENGTH OF STAY IN lb: 6 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PULLEN NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: ILLINOIS (MARYLAND) — b. COUNTY: COOK Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WILMETTE
d. STREET ADDRESS: 1235 ELMWOOD AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ANNE — Middle: ELIZABETH — Last: MC KINSEY

4. DATE OF DEATH: Month: JAN. — Day: 23 — Year: 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: JAN. 9, 1890

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE-WIFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): ANNE ARUNDLE Co. MD.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ROBT. J. GRAY

14. MOTHER'S MAIDEN NAME: ELLEN BOYD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 067-09-9513D

17. INFORMANT: WOERNER McKINSEY, JR. — Address: 1235 ELMWOOD AVE. WILMETTE. ILL.

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Arrest

DUE TO (b): Arteriosclerotic Heart Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..., 19..., to Jan 18, ..., 1967, that (I) (we) last saw the deceased alive on Jan 18, ..., 1967, and that death occurred at 5 P.M. from the causes and on the date stated above.

22a. SIGNATURE: John S. Harshey M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/23/67

22c. PHYSICIAN'S NAME (Type): JOHN S. HARSHEY, M.D.

22d. ADDRESS: 8 Church St. Westminster Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 1/26/67 — 23c. NAME OF CEMETERY OR CREMATORY: MEADOW BRANCH CEM. — 23d. LOCATION (City, town or county) (State): RURAL, WESTMINSTER, MD

24. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr. — ADDRESS: Westminster, Md.

25a. REC'D BY REGISTRAR DATE: JAN 27 1967 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 62

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00540

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00543

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: Hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll County General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood
d. STREET ADDRESS: 2406 Sycamore Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hosea — Middle: — Last: Morris Jr.

4. DATE OF DEATH: Month: January — Day: 2 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/27/31

9. AGE (In years last birthday): 35 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipe Fitter

10b. KIND OF BUSINESS OR INDUSTRY: Beth. Steel Co.

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Hosea Morris Sr.

14. MOTHER'S MAIDEN NAME: Maude Bailey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes — 2/1/51 11/9/55

16. SOCIAL SECURITY NO.: 233-42-8163

17. INFORMANT (Wife) Address: Mrs. Huberta Morris, 2406 Sycamore Lane, Edgewood, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis (Acute) — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W. Glenn Speicher, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): W. Glenn Speicher

Address (Street, city, town, or county): 1825 Greenmount Ave., Baltimore, Md.

22. DATE SIGNED: 1-2-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/6/67

23c. NAME OF CEMETERY OR CREMATORY: Gardens of Faith Cem.

23d. LOCATION (City, town or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR: John J. Duda — ADDRESS: 7922 Wise Ave. Dundalk, Md.

25a. REC'D BY REGISTRAR DATE: JAN 5 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00541

CERTIFICATE OF DEATH

00544

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2yrs.7mos.5dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 14511 Colesville Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARGARET — Middle: LORETTA — Last: O'KELLY

4. DATE OF DEATH: Month: JANUARY — Day: 31 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-15-1879

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nicholas Meehan

14. MOTHER'S MAIDEN NAME: Margaret Cosgrove

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 360-09-7255

17. INFORMANT: Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome with senile brain disease, with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6-26-64, 19__ to 1-31-67, 19__, that (I) (we) last saw the deceased alive on 1-31-67, 19__, and that death occurred at 10:35 A.M. P.M. from causes and on the date stated above.

22a. SIGNATURE: Antonius Glahn, M.D. — ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 2/1/67

22c. PHYSICIAN'S NAME (Type): Antonius Glahn, M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3 Feb. 1967

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery

23d. LOCATION (City or Town) (County) (State): Silver Spring, Md.

24. FUNERAL DIRECTOR: Rinaldi Funeral Home, Inc. 7400 Ga. Ave., NW — ADDRESS: Wash., DC

25a. REC'D BY REGISTRAR: DATE: FEB 3 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00542

CERTIFICATE OF DEATH

00545

1. PLACE OF DEATH
a COUNTY: Carroll — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Sykesville
c. LENGTH OF STAY IN 1b: 4mo. 21days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: Maryland — b COUNTY: Montgomery
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d STREET ADDRESS: 1304 Wheaton Lane
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Martha — Middle: Betford — Last: Payne
4. DATE OF DEATH: Month: 1 — Day: 6 — Year: 19 67
5. SEX: female
6. COLOR OR RACE: negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 07/14/86
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hiram W. Payne
14. MOTHER'S MAIDEN NAME: Charity Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 218-38-8106
17. INFORMANT Address: Springfield Hospital records, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO
(b): Cerebrovascular accident — days
DUE TO
(c): Sickles cell anemia — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 8/15/ , 1966 to 1/6/ , 1967 , that ☐ (we) last saw the deceased alive on 1/6/ 67 , and that death occurred at 3:20 a.m., from causes and on the date stated above.

22a SIGNATURE: Naci N. Buyukunsal M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 1/6/67
22c. PHYSICIAN'S NAME (Type): Naci N. Buyukunsal, M.D.
22d ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-11-67
23c NAME OF CEMETERY OR CREMATORY: Lincoln Memorial.,
23d LOCATION (City or Town) Sulti[illegible], Md. (County) (State)

24. FUNERAL DIRECTOR: Robert C. Snowden
ADDRESS: Rockville
25a. REC'D BY REGISTRAR DATE: JAN 10 1967
25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00543

CERTIFICATE OF DEATH

00546

1 PLACE OF DEATH
a. COUNTY Carroll MARYLAND

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Md. b. COUNTY Carroll

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 619 Baltimore Boulevard

d. STREET ADDRESS 619 Baltimore Boulevard

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First: Mabel Middle: R. Last: Peeling

4. DATE OF DEATH Month: January Day: 21, Year: 19 67

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: March 28, 1911

9. AGE (In years last birthday) 55 yrs.

IF UNDER 1 YEAR Months / Days

IF UNDER 24 HRS. Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician

10b KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (County & State, or foreign country) Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME Harvey Freed

14. MOTHER'S MAIDEN NAME Minnie Rudisill

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)

16 SOCIAL SECURITY NO 220-16-3273

17 INFORMANT Mr. Rodger R. Peeling Address Westminster, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis began in

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) lung
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 7 Mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 4, 1966, to Jan 21, 1967, that (I) (we) last saw the deceased alive on Jan 20 1967, and that death occurred at 2:45A M, from causes and on the date stated above.

22a. SIGNATURE Julius Chepko M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED 1/21/67

22c PHYSICIAN'S NAME (Type) Julius Chepko

22d ADDRESS 8 S. W. Green St. Westminster, Md

23a BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF Jan. 23, 1967

23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial

23d LOCATION (City or Town) (County) (State) Finksburg, Md.

24 FUNERAL DIRECTOR ADDRESS J. F. Eline & Sons Reisterstown, Md.

25a REC'D BY REGISTRAR DATE JAN 24 1967

25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal. In any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00544

CERTIFICATE OF DEATH

00547

1. PLACE OF DEATH
a. COUNTY: CARROLL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 50 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CARROLL CO. GEN. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
d. STREET ADDRESS: 138 E. MAIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle DAVID Last POISEL, JR.
4. DATE OF DEATH: Month 1 Day 6 Year 1967
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JAN. 14. 1883
9. AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WORKED IN LUMBER SUPPLY, RETAIL
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): CARROLL CO. MD.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: JOHN DAVID POISEL
14. MOTHER'S MAIDEN NAME: STEPHANIE WINKNER
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 213-05-1708
17. INFORMANT: MR. PAUL H. POISEL, WESTMINSTER, Address: RR #4 Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 72 HOURS
DUE TO (b): HYPERTENSIVE AND
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): ARTERIOSCLEROTIC HEART DISEASE — YEARS

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/3, 1967, to 1/6, 1967, that (I) (we) last saw the deceased alive on 1/6 1967, and that death occurred at 11:10 M, from causes and on the date stated above.

22a. SIGNATURE: Vincent J. Fusco Jr. M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/6/67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1/9/67
23c. NAME OF CEMETERY OR CREMATORY: SANDYMOUNT CEM.
23d. LOCATION (City or Town) (County) (State): FINKSBURG RD 1 Md.
24. FUNERAL DIRECTOR: J. E. Myers Jr. ADDRESS: Westminster, Md.
25a. REC'D BY REGISTRAR DATE: JAN 9 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00545

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00548

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Route 3 Sykesville
   c. LENGTH OF STAY IN 1b: Never
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 26

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Baltimore
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Reisterstown
   d. STREET ADDRESS: Route 3
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Stephen — Middle: Hatton — Last: Ray

4. DATE OF DEATH: Month: Jan. — Day: 1, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-2-47

9. AGE (In years last birthday): 19 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Navy

10b. KIND OF BUSINESS OR INDUSTRY: Government

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph H. Ray, Sr.

14. MOTHER'S MAIDEN NAME: Ruth E. Peddicord

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
    (If yes give war or dates of service): Presently

16. SOCIAL SECURITY NO.: 212-52-6908

17. INFORMANT — Address: Mr. Joseph Ray, Jr. Reisterstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fractured Skull & Neck
DUE TO (b): Compound Fractures both Femurs & Left Forearm
DUE TO (c): Multiple Lacerations & Crushed Chest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

816.4

INTERVAL BETWEEN ONSET AND DEATH: Instant

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Head on Collision

20c. TIME OF INJURY: Hour, A.M. or P.M.: 12:30 p.m. — Month, Day, Year: 1-1 1967

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 26

20f. (City or town) (County) (State): Kilby Hassill-Carroll-Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W. Lowe Speicher M.D.

EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town or county): [illegible] Westminster

22. DATE SIGNED: 1-1-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1-5-67

23c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery

23d. LOCATION (City, town or county) (State): Howard Co. Md.

24. FUNERAL DIRECTOR — ADDRESS: Harry W. Haight — Sykesville, Md

25a. REC'D BY REGISTRAR — DATE: JAN 10 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME
3500 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film G985 2/10/67 h

CERTIFICATE OF DEATH

00546 00549

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Sykesville
c. LENGTH OF STAY IN 1b: 2mo. 16days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Sykesville
d. STREET ADDRESS: Gaither Road, Route 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marian — Middle: Anna — Last: Reinhardt

4. DATE OF DEATH: Month: 1 — Day: 30 — Year: 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☒
8. DATE OF BIRTH: 8/19/91
9. AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): secretary
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Adrian Hughes
14. MOTHER'S MAIDEN NAME: Anna Maria Burch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT — Address: Springfield Hospital records, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart failure — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO
(b): Arteriosclerotic heart Disease — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c): Supperative nephritis left kidney — weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with cerebral arteriosclerosis with behavioral reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from 11/11/, 1966, to 1/30/, 1967, that ☒ (we) last saw the deceased alive on 1/30/ 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: Naci N. Buyukunsal M.D — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 1/30/67
22c. PHYSICIAN'S NAME (Type): Naci N. Buyukunsal, M. D.
22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 2/2/67
23c. NAME OF CEMETERY OR CREMATORY: NEW CATHEDRAL
23d. LOCATION (City or Town) (County) (State): BALTIMORE, MD.

24. FUNERAL DIRECTOR — ADDRESS: N.W. MEARS & SON 805 N. CALVERT ST.
25a. REC'D BY REGISTRAR — DATE: FEB 3 1967
25b. REGISTRAR'S SIGNATURE

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in part 20. Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00547

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00550

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster - rural
c. LENGTH OF STAY IN 1b: 50 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rd. 6

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster -rural
d. STREET ADDRESS: Rd.6
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EVA Eva — Middle: Doris DAVIS — Last: Rowe

4. DATE OF DEATH: Month: 1 — Day: 20 — Year: 19 67

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 11, 1897

9. AGE (In years last birthday): 69 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Carroll County, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: E. Leonard Davis

14. MOTHER'S MAIDEN NAME: Mary E. Ditman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): -- (If yes give war or dates of service): --

16. SOCIAL SECURITY NO: ?

17. INFORMANT: Mrs. Sadie B. Ditman- Address: Westminster RD 6 Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Massive spontaneous intracerebral hemorrhage
DUE TO (b):
DUE TO (c):
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz, M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county):

22. DATE SIGNED: 1/21/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/24/67

23c. NAME OF CEMETERY OR CREMATORY: Deer Park Cemetery

23d. LOCATION (City or Town) (County) (State): Westminster RD6 Md.

24. FUNERAL DIRECTOR: J. E. Myers Jr. ADDRESS: Westminster, Md.

25a. REC'D BY REGISTRAR DATE: JAN 24 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Yingling

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00548 **CERTIFICATE OF DEATH** 00551

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1042 N. Calvert St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle EVERETT — Last SHEENE Sr.

4. DATE OF DEATH: Month JANUARY — Day 25 — Year 1967

5. SEX: M

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ Separated

8. DATE OF BIRTH: 5-7-85

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (County & State, or foreign country): Massachusetts

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Horace William Sheene

14. MOTHER'S MAIDEN NAME: Elizabeth Crane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 216-01-1038

17. INFORMANT Address: Records of Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Circulatory failure — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO (b): Atherosclerosis — Years
DUE TO (c): Pneumonitis — Days

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with cerebral arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-5-63, 19__, to 1/25/, 1967, that (I) (we) last saw the deceased alive on 1/25/ 1967, and that death occurred at 1:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Adnan Sonmez M.D. — M.O. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1/25/67

22c. PHYSICIAN'S NAME (Type): Adnan M. SONMEZ

22d. ADDRESS: Springfield State hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 1-28-67

23c. NAME OF CEMETERY OR CREMATORY: Loudon Park

23d. LOCATION (City, town or county) (State): Baltimore Md

24. FUNERAL DIRECTOR — ADDRESS: Geo. L. Schwab Funeral Home. Francis V. Miller 2101 Eutaw Place.

25a. REC'D BY REGISTRAR DATE: JAN 30 1967

25b. REGISTRAR'S SIGNATURE: Charles Jutze

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00549

CERTIFICATE OF DEATH

00552

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: CARROLL CO. — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
   c. LENGTH OF STAY IN 1b: 11 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CARROLL CO. GEN. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: CARROLL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION MILLS, WESTMINSTER RT#1
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: MARY — Middle: MADELINE — Last: SHRIVER

4. DATE OF DEATH: Month: 1 — Day: 31 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 3, 1879

9. AGE (In years last birthday): 88 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): UNION MILLS, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: B. FRANK SHRIVER

14. MOTHER'S MAIDEN NAME: HELEN CARBERY MC SHERRY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: MR. JAMES M. SHRIVER, WESTMINSTER, MD — Address: RT#1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 11 DAYS
   DUE TO (b): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — YEARS
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   DUE TO (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): PNEUMONITIS - RLL

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m., 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 1/20, 1967, to 1/31, 1967 that (I) (we) last saw the deceased alive on 1/31 1967, and that death occurred at 8:15 M, from causes and on the date stated above.

22a. SIGNATURE: Vincent J. Fiocco Jr. M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/31/67

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2/3/67

23c. NAME OF CEMETERY OR CREMATORY: ST. JOHNS CEMETERY

23d. LOCATION (City or Town) (County) (State): WESTMINSTER MD

24. FUNERAL DIRECTOR — ADDRESS: J. E. Myers Jr., Westminster, Md.

25a. REC'D BY REGISTRAR — DATE: FEB 3 1967

25b. REGISTRAR'S SIGNATURE:

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00550 00553

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A11 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Maryland — b. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Rural--Sykesville c. LENGTH OF STAY IN 1b: 7yr. 2mo. 2 da.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hampstead, Maryland
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital	d. STREET ADDRESS: R.F.D. #1 e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First [illegible]	Middle: MARY	Last: SIMMONS	4. DATE OF DEATH: Month 1	Day 18	Year 1967			
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: 9-26-84	9. AGE (In years last birthday): 82 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: --	11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William T. Lawson		14. MOTHER'S MAIDEN NAME: Emmelid Hare	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16. SOCIAL SECURITY NO.: 220-54-6986 none*	17. INFORMANT: Springfield Hospital Records, Sykesville, Address Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH
420.0
DUE TO (b): Generalized Arteriosclerotic Vascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Cerebral Arteriosclerosis.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that (☒) (this hospital) attended the deceased from 11-17- , 19 59, to 1-18 , 1967, that (☒) (we) last saw the deceased alive on 1-18- 19 67, and that death occurred at 11:30 a.m. from causes and on the date stated above.

22a. SIGNATURE: Frances Reid Nabors, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ Res STAFF PHYS ☒	22b. DATE SIGNED: 1-19-67		
22c. PHYSICIAN'S NAME (Type): Frances Reid Nabors, M.D.	22d. ADDRESS: Springfield State Hospital Sykesville, Maryland		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: Jan. 21, 1967	23c. NAME OF CEMETERY OR CREMATORY: Snydersburg Cemetery	23d. LOCATION (City or Town) (County) (State): Snydersburg Carroll Md.
24. FUNERAL DIRECTOR: Tipton * Eline Funeral Home	ADDRESS: Hampstead, Md.	25a. REC'D BY REGISTRAR DATE JAN 20 1967	25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00551 — 00554

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: Hour
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rt. 26 ¼ mile East of Rt. 97

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERNARD — Middle A. — Last SMITH

4. DATE OF DEATH: Month January — Day 14, — Year 1967

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 16, 1937

9. AGE (In years last birthday): 29 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Carroll Co., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Margaret O. Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: ?

17. INFORMANT — Address: Mrs. Margaret O. Smith Libertytown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fractured Skull & multiple
DUE TO (b): Traumatic Injuries
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Instant

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Hit & Run Driver. Route 26 Libertytown

20c. TIME OF INJURY Month, Day, Year: 3:30 Hour a.m. p.m. 1-14 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 26

20f. (City or town): Sykesville (County): Carroll (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W. Glenn Speicher M.D.

EXAMINER'S NAME (Type): W. Glenn Speicher

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Libertytown, Carroll (State)

22. DATE SIGNED: 1-14-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/16/1967

23c. NAME OF CEMETERY OR CREMATORY: Bushy Park

23d. LOCATION (City, town or county): Howard Co., Md. (State)

24. FUNERAL DIRECTOR — ADDRESS: C. M. Waltz Box 241 Sykesville, Md.

25a. REC'D BY REGISTRAR — DATE: JAN 17 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00552 00555

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 5 mos./8 das.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown 21740
d. STREET ADDRESS: Unk.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma; Middle: Alberta; Last: SPRINGER

4. DATE OF DEATH: Month: January; Day: 15; Year: 19 67

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2-22-1899
9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Nunamaker - dec.
14. MOTHER'S MAIDEN NAME: Nettie Jordan - dec.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 220-28-3806
17. INFORMANT Address: Springfield State Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart failure due to coronary artery insufficiency — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO
(b): Diabetes — Years
DUE TO
(c): Aspiration bronchopneumonia — Day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
260X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenic reaction, chronic undifferentiated type.
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-6-66, 19___, to 1-15-67, 19___, that (I) (we) last saw the deceased alive on 1-15-67 19___, and that death occurred at 9:15 a.m. p.m. from causes and on the date stated above.

22a. SIGNATURE: Dr. Antonius Glahn M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 1-15-67
22c. PHYSICIAN'S NAME (Type): Antonius Glahn, M.D.
22d. ADDRESS: Springfield State Hospital Sykesville, Maryland 21784

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/18/67
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Hagerstown Wash Co Md

24. FUNERAL DIRECTOR: Andr W K. Coffman Funeral Home Inc
ADDRESS: Hagerstown Md
25a. REC'D BY REGISTRAR DATE: JAN 19 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

Lt · 13 Film 3 4 1-11-67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00553

CERTIFICATE OF DEATH

00556

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit; then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: CARROLL Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 50 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CARROLL CO GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
d. STREET ADDRESS: 105 EAST MAIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First RALPH Middle DIEHL Last STARNER

4. DATE OF DEATH: Month 1 Day 1 Year 1967

5. SEX: Male FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: FEB 9 1895

9. AGE (In years last birthday): 71 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OPERATOR RUG BASE FACTORY

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): CARROLL CO. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CALVIN R. STARNER

14. MOTHER'S MAIDEN NAME: IOWA PETRY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): —

16. SOCIAL SECURITY NO: 213-05-3297

17. INFORMANT: REESE L. STARNER — Address: 201 HIGHLAND DRIVE WESTMINSTER MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): MENINGITIS — INTERVAL BETWEEN ONSET AND DEATH: 1 DAY
DUE TO (b): B-hemolytic Streptococcus
DUE TO (c): ___
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 340.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ARTERIOSCLEROSIS GENERALIZED.

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 12/31, 1966 to 1/1, 1967, that (I) (we) last saw the deceased alive on 1/1 1967, and that death occurred at 2:55 P M, from causes and on the date stated above.

22a. SIGNATURE: Vincent J. Fidco Jr — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/1/67

22c. PHYSICIAN'S NAME (Type): VINCENT J. FIDCO JR

22d. ADDRESS: WESTMINSTER, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1/4/67

23c. NAME OF CEMETERY ~~OR CREMATORY~~: BAUST CHURCH CEMETERY

23d. LOCATION (City or Town) (County) (State): WESTMINSTER R.D. Md

24. FUNERAL DIRECTOR: J. E. Myers Jr. — ADDRESS: Westminster, Md

25a. REC'D BY REGISTRAR DATE: JAN 4 1967

25b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00554 00557

1. PLACE OF DEATH — a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westminster Md #3
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Westminster Md #3

2. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission) — a. STATE: Md — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westminster Md #3
d. STREET ADDRESS: #3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rosie — Middle: German — Last: Stonesifer
4. DATE OF DEATH: Month: January — Day: 23 — Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/13/1899
9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired 1962 Cities Svc Co
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Carroll Co Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William H. Stonesifer
14. MOTHER'S MAIDEN NAME: Annie R. German
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 223-01-9970
17. INFORMANT — Address: Gertrude Stonesifer Westminster Md #3

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 3 Mos
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): Carcinoma of urinary bladder — 1 yr.
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/10, 1962, to 1/23, 1967, that (I) (we) last saw the deceased alive on 1/23 1967, and that death occurred at 1:45 P M, from the causes and on the date stated above.

22a. SIGNATURE: Julius Chepko — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/23/67
22c. PHYSICIAN'S NAME (Type): Julius Chepko
22d. ADDRESS: 65 W. Green St Westminster, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/26/67
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
23d. LOCATION (City, town or county) (State): Hanover Pa
24. FUNERAL DIRECTOR: Wayne C. Kennedy — ADDRESS: 29 Frederick St Hanover Pa
25a. REC'D BY REGISTRAR — DATE: JAN 27 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00555 00558

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 50YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 73 BOND ST.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
d. STREET ADDRESS: 112 PENNA. AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNA Middle ELIZABETH Last TAYLOR

4. DATE OF DEATH: Month JAN. Day 5 Year 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JUNE 30, 1908

9. AGE (In years last birthday): 58 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OPERATOR

10b. KIND OF BUSINESS OR INDUSTRY: CLOTHING FACTORY

11. BIRTHPLACE (County & State, or foreign country): UNION MILLS CARROLL MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: NORMAN H. EARHART

14. MOTHER'S MAIDEN NAME: CARRIE V. WAREHIME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 213-05-1539

17. INFORMANT: MR. NORMAN H. EARHART Address: 73 BOND ST. WESTMINSTER MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Brain Tumor (Glioma) — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs 3 mos
DUE TO (b): Lt Parietal Region
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 21, 1965 to Jan 5, 1967, that (I) (we) last saw the deceased alive on Dec 29, 1966, and that death occurred at 1:50 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Wilbur Speicher M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1-5-67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1/7/67

23c. NAME OF CEMETERY OR CREMATORY: ST. MARYS CEMETERY

23d. LOCATION (City, town or county) (State): SILVER RUN CARROLL CO. MD

24. FUNERAL DIRECTOR: J. E. Myers Jr. ADDRESS: Westminster, Md

25a. REC'D BY REGISTRAR DATE: JAN 9 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00556

CERTIFICATE OF DEATH

00559

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hampstead
c. LENGTH OF STAY IN 1b: 60 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Main St.

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md. b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hampstead
d. STREET ADDRESS: Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lulu Middle: M. Last: Tracey
4. DATE OF DEATH: Month: Jan. Day: 26, Year: 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 4, 1889
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State or foreign country): Balto. Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jerome Nolte
14. MOTHER'S MAIDEN NAME: Amelia Foltz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: 212-40-4629
17. INFORMANT: Dr. Grace L. Tracey Address: Hampstead, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Same
DUE TO (b): Coronary Arteriosclerosis — 3 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from [illegible], 19 [illegible] to Jan. 26, 19 67, that (I) (we) last saw the deceased alive on Jan. 26 19 67, and that death occurred at 6:15 P.M. from causes and on the date stated above.

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-27-67
22c. PHYSICIAN'S NAME (Type): M.C.Porterfield
22d. ADDRESS: Hampstead, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 29, 1967
23c. NAME OF CEMETERY OR CREMATORY: Pleasant Grove Cemetery
23d. LOCATION (City or Town) (County) (State): Borning Balto. Co. Md.

24. FUNERAL DIRECTOR ADDRESS: Tipton-Eline Funeral Home Hampstead, Md.
25a. REC'D BY REGISTRAR DATE: JAN 30 1967
25b. REGISTRAR'S SIGNATURE: [signature]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00557

CERTIFICATE OF DEATH

00560

1. PLACE OF DEATH
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 6 mons 16 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 1716 Gruenther Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert Middle: H. X Last: Vencill

4. DATE OF DEATH: Month: 1 Day: 8 Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6-21-82

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Vencill

14. MOTHER'S MAIDEN NAME: Leah Addison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 230-42-9681

17. INFORMANT: Records - Springfield State Hospital
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL INFARCTION, Left occipital
DUE TO (b): CEREBRAL ARTERIOSCLEROSIS
DUE TO (c): BRONCHOPNEUMONIA

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: (a) minutes or days; (b) years; (c) days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-22, 1966, to 1-8, 1967, that (I) (we) last saw the deceased alive on 1-8 1967, and that death occurred at 6A.M, from the causes and on the date stated above.

22a. SIGNATURE: Adnan Sonmez M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1/8/1967

22c. PHYSICIAN'S NAME (Type): ADNAN SONMEZ

22d. ADDRESS: Springfield State hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit

23b. DATE THEREOF: 1-9-67

23c. NAME OF CEMETERY OR CREMATORY: Maplewood Cemetery

23d. LOCATION (City, town or county) (State): Tazewell, Virginia

24. FUNERAL DIRECTOR ADDRESS: ROBERT A. PUMPHREY, Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE: JAN 13 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00558

CERTIFICATE OF DEATH

00561

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester
c. LENGTH OF STAY IN 1b: 12 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Manchester Rd 1

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester
d. STREET ADDRESS: Rd 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clair — Middle: F. — Last: Weaver

4. DATE OF DEATH: Month: Jan. — Day: 20, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 29, 1903

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (County & State, or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Albert D. Weaver

14. MOTHER'S MAIDEN NAME: Emma K. Noel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 176-05-2247

17. INFORMANT: Hilda V. Weaver — Address: Manchester Rd 1 Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Primary Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1621

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m., 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July, 19 66, to 1-20, 19 67, that (I) (we) last saw the deceased alive on 1-20 19 67, and that death occurred at 5:15 P M, from causes and on the date stated above.

22a. SIGNATURE: M.C. Porterfield — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1-21-67

22c. PHYSICIAN'S NAME (Type): M.C.Porterfield,M.D.

22d. ADDRESS: Hampstead,Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 23, 1967

23c. NAME OF CEMETERY OR CREMATORY: Immanuel Cemetery

23d. LOCATION (City or Town) (County) (State): Manchester Carroll Md.

24 FUNERAL DIRECTOR — ADDRESS: Tipton - Eline Funeral Home Hampstead, Md.

25a. REC'D BY REGISTRAR DATE: JAN 24 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00559

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00562

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Sykesville
c. LENGTH OF STAY IN 1b: ?
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 26 Nr. Eldersburg

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Sykesville
d. STREET ADDRESS: Route 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WILDON — Middle: W. — Last: WILL

4. DATE OF DEATH: Month: January — Day: 1 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 1, 1925

9. AGE (In years last birthday): 41 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Butcher

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Carroll Co., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frederick Will

14. MOTHER'S MAIDEN NAME: Lottie Knauff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW 2

16. SOCIAL SECURITY NO.: 220-16-3659

17. INFORMANT: Mrs. Pearl W. Will — Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fractured Skull, Head Injuries
DUE TO (b): Compound Fracture L. Femur
DUE TO (c): Crushed Chest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Instant

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Head on Collision

20c. TIME OF INJURY Month, Day, Year: Hour 12:24 p.m. 1-1 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 26

20f. (City or town) (County) (State): Sykesville Carroll Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W. Glenn Speicher M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): W. Glenn Speicher

Address (Street, city, town, or county): 13 Esslie Rd Westminster Md

22. DATE SIGNED: 1-5-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 5, 1967

23c. NAME OF CEMETERY: Lakeview Mem. Gardens

23d. LOCATION (City, town or county) (State): Carroll Co., Md.

24. FUNERAL DIRECTOR — ADDRESS: C. M. Waltz Box 241 Sykesville, Md.

25a. REC'D BY REGISTRAR — DATE: JAN 4 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00560

CERTIFICATE OF DEATH

00563

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Carroll
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester, Md
   c. LENGTH OF STAY IN 1b: Just 6 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Ingrams Nursing Home 128 2 Main St

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md
   b. COUNTY: Balto.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glyndon Md.
   d. STREET ADDRESS: 14 Glyndon Ave
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Morris Middle: P. Last: Wilson

4. DATE OF DEATH: Month: 1 - 12 Day: Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Aug 13, 1883

9. AGE (In years last birthday): 83 yrs.
   IF UNDER 1 YEAR: Months: Days:
   IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Banker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Calvert Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James P. Wilson

14. MOTHER'S MAIDEN NAME: Sara Chaney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
    (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 213-28-0453A

17. INFORMANT: Maynie Wilson. Address: 14 Glyndon Ave. Glyndon, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute heart failure — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardiovascular Disease — 5 yrs
DUE TO (c): Cerebral Arteriosclerosis — 5 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/23, 1966, to 1/12, 1967, that (I) (we) last saw the deceased alive on 1/12/1967, and that death occurred at 12:55 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W H Foard M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/12/67

22c. PHYSICIAN'S NAME (Type): W. H. Foard M D

22d. ADDRESS: Manchester, Md 21102

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1-14-67

23c. NAME OF CEMETERY OR CREMATORY: DRUID RIDGE

23d. LOCATION (City, town or county) (State): PIKESVILLE, MD. 21208

24. FUNERAL DIRECTOR: WM. Cook-Brooks Towson, Inc, Towson, MD ADDRESS: 21204

25a. REC'D BY REGISTRAR DATE: JAN 16 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00561

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00564

1. PLACE OF DEATH
e. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: ~~YEARS~~
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Barthlow Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE: Md. b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
d. STREET ADDRESS: Route 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Willie · Middle: STEPHEN · Last: WILSON

4. DATE OF DEATH: Month: JAN. Day: 20, Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 18, 1945

9. AGE (In years last birthday): 21 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Hospital

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Willie Wilson

14. MOTHER'S MAIDEN NAME: Mary Colifek

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 219-42-9214

17. INFORMANT: Address: Mr. Willie Wilson - Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Exsanguination
DUE TO (b): Laceration
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 2 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Run into by Ford Pickup truck

20c. TIME OF INJURY Month, Day, Year: Hour 6:15 a.m. p.m. 1-20 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Barthlow Rd

20f. (City or town) Rd Sykesville (County) Carroll (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: William Speicher M.D.

EXAMINER'S NAME (Type): W. Glenn Speicher

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): 135 Eldersburg Carroll

22. DATE SIGNED: 1-20-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1-28-67

23c. NAME OF CEMETERY OR CREMATORY: Lake View Cemetery

23d. LOCATION (City, town or county) (State): Sykesville, Md.

24. FUNERAL DIRECTOR: Harry W. Haight ADDRESS: Sykesville, Md.

25a. REC'D BY REGISTRAR DATE: JAN 26 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00562

CERTIFICATE OF DEATH

00565

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr.8mos.3dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 732 South Charles St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle W. — Last WRIGHT

4. DATE OF DEATH: Month JANUARY — Day 16 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-5-04

9. AGE (In years last birthday): 62 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Matt Wright

14. MOTHER'S MAIDEN NAME: Mary (last name unk.)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Records, Springfield State Hospital — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular accident
DUE TO (b):
DUE TO (c): Far advanced pulmonary tuberculosis, quiescent

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: Weeks / Years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome assoc. with convulsive disorder, without qualifying phrase

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-13-64, 19__ to 1-16-67, 19__, that (I) (we) last saw the deceased alive on 1-16-67, 19__, and that death occurred at 8:30 A.M., from causes and on the date stated above.

22a. SIGNATURE: Julian Radzykewycz M.D — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1-16-67

22c. PHYSICIAN'S NAME (Type): Julian Radzykewycz, M. D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/19/67

23c. NAME OF CEMETERY OR CREMATORY: mt Calvary

23d. LOCATION (City or Town) (County) (State): a a Co, Md

24. FUNERAL DIRECTOR: D L Brown & Son — ADDRESS: 108 N Montgomery St

25a. REC'D BY REGISTRAR DATE: JAN 20 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00563

CERTIFICATE OF DEATH

00566

1. PLACE OF DEATH
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural
c. LENGTH OF STAY IN 1b: years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Bridge

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Union Bridge
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Thomas Middle William Last Yates
4. DATE OF DEATH: Month January Day 21, Year 19 67

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: July 9, 1872
9. AGE (In years last birthday): 94 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Steel Mill
11 BIRTHPLACE (County & State, or foreign country): Ormsby, Yorkshire England.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Philip Yates
14 MOTHER'S MAIDEN NAME: Margaret Mills

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 193-05-6945
17. INFORMANT Address: Mrs. Earle L. Buckey, Union Bridge, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Infiltrating Carcinoma of the Stomach
DUE TO (b): (Linitus Plastica)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: Several Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Carcinoma of the ascending Colon
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town, (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1958, 19, to 1/21/67, 19, that (I) (we) last saw the deceased alive on 1/21/67 19, and that death occurred at 9 P.M. from the causes and on the date stated above.

22a. SIGNATURE: J. H. Caricofe M.D.
ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 1/21/67
22c. PHYSICIAN'S NAME (Type): J. H. CARICOFE
22d. ADDRESS: Union Bridge, Md. 21791

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 1/24/1967
23c. NAME OF CEMETERY OR CREMATORY: Pipe Creek Cemetery
23d. LOCATION (City, town or county) (State): Carroll County, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: D. H. Harbaugh Sons
ADDRESS: Union Bridge, Md.
25a. REC'D BY REGISTRAR DATE: JAN 24 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4) 15M 7-62

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
1SM 7-62

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00564 — 00567

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 19 N MAIN ST.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
d. STREET ADDRESS: 19N MAIN ST
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EVELYN — Middle: J. — Last: YINGLING

4. DATE OF DEATH: Month: JAN — Day: 6 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT 2 - 1905

9. AGE (In years last birthday): 61 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SUPERVISOR

10b. KIND OF BUSINESS OR INDUSTRY: CLOTHING CO

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: EDWARD JUNG

14. MOTHER'S MAIDEN NAME: LULU McKINNEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 216-05-1799

17. INFORMANT: FENTON YINGLING — Address: UNION BRIDGE MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the Cervix with bony Metastasis.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 4 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour e.m. p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1962, 19..... to 1/6/67, 19....., that (I) (we) last saw the deceased alive on 1/5/67 19....., and that death occurred at 5 A M, from the causes and on the date stated above

22a. SIGNATURE: J H Carrcfo M.D

22c. PHYSICIAN'S NAME (Type): J. H. CARROLL

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/6/67

22d. ADDRESS: N. MAIN ST. Extended, Union Bridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JAN 9- 1967

23c. NAME OF CEMETERY OR CREMATORY: WINTERS

23d. LOCATION (City, town or county) (State): NEW WINDSOR RURAL MD

24 FUNERAL DIRECTOR'S SIGNATURE: D D Hartzler & Sons — ADDRESS: Union Bridge, Md

25a. REC'D BY REGISTRAR DATE: JAN 9 1967 — 25b. REGISTRAR'S SIGNATURE: [illegible] Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00565 — **CERTIFICATE OF DEATH** — 00568

Item 9 Film G385 1/24/67 mh

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Manchester, md.
c. LENGTH OF STAY IN 1b: 5 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Longview Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster, Md
d. STREET ADDRESS: 15 Chase St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frances — Middle: B. — Last: Zepp.

4. DATE OF DEATH: Month: 1 — Day: 17 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-14-1871

9. AGE (In years last birthday): 9195 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): Carroll Co.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John F. Buffington

14. MOTHER'S MAIDEN NAME: Agnes Anne Porter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 216-46-3266

17. INFORMANT: Mrs Irving Andrews. Address: nee Wash. DC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: —
DUE TO (b): Arteriosclerosis and Senile Dementia
DUE TO (c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 13, 1962 to Jan 17, 1966, that (I) (we) last saw the deceased alive on Jan. 13 1967, and that death occurred at 5:35 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Joseph E Bush M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/17/67

22c. PHYSICIAN'S NAME (Type): Joseph E Bush MD

22d. ADDRESS: HAMPSTEAD Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/20/67

23c. NAME OF CEMETERY OR CREMATORY: TANEYTOWN LUTH. CEMETERY

23d. LOCATION (City, town or county) (State): TANEYTOWN, MARYLAND

24. FUNERAL DIRECTOR: J. S. Myers, Jr. — ADDRESS: Westminster, Md.

25a. REC'D BY REGISTRAR DATE: JAN 19 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00566

CERTIFICATE OF DEATH

00569

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Carroll Co. — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westminster
   c. LENGTH OF STAY IN 1b: 3 Years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Meadow View Conv. Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Pa. — b. COUNTY: Adams
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gettysburg — 15.3
   d. STREET ADDRESS: 18 N. Washington St
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Zella — Middle May — Last Ziegler Zeigler

4. DATE OF DEATH: Month Jan. — Day 11 — Year 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4/1/1883

9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Orangeville, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jerome DeLong

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Samuel H. Ziegler Columbus Ohio

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gastroenteritis - viral — INTERVAL BETWEEN ONSET AND DEATH: 1 week
571.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cardiac failure, Cerebrovascular arteriosclerosis, senility — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov 1, 1963, to Jan 11, 1967, that (I) (we) last saw the deceased alive on Jan 11 1967, and that death occurred at 8:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Julius Chepko — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/12/67

22c. PHYSICIAN'S NAME (Type): Julius Chepko

22d. ADDRESS: 85 W. Green St. Westminster Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/14/1967

23c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery

23d. LOCATION (City, town or county) (State): Gettysburg, Adams Co. Pa.

24. FUNERAL DIRECTOR: Ralph J. Minnich — ADDRESS: Gettysburg, Pa.

25a. REC'D BY REGISTRAR — DATE: JAN 17 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64